# Improved Decision Making in Child Maltreatment Cases

**Raelene Freitag, M.S.W., Ph.D.**
*National Council on Crime and Delinquency*

**Madeline Wordes, Ph.D.**
*National Council on Crime and Delinquency*

The decisions child protective agencies make are complex and critical to reducing further maltreatment and potential delinquent behavior. Given the numbers and severity of cases that present to child agencies, the difficulty of making appropriate discretionary decisions, and limited staffing and services, agencies are looking to structured decision-making systems to help them respond appropriately to reports of abuse and neglect. This article describes principles and elements of the structured decision-making (SDM) system developed by the Children's Research Center of the National Council on Crime and Delinquency and reports results of studies on the use of this tool. ■

Delinquency prevention efforts ideally encompass a broad array of interventions, from smaller class sizes in early school years to after-school recreation to gang crisis intervention and mediation to intensified motorized police patrols.[1] But even more fundamental to preventing delinquency is the reduction of child maltreatment.[2] An emerging body of research points persuasively to a strong link between the experience of abuse or neglect and subsequent delinquent behavior.

The National Council on Crime and Delinquency has conducted a number of actuarial research studies designed to develop tools to categorize juvenile parolees and probationers on the basis of their likelihood to repeat delinquent behavior. Repeatedly these actuarial studies identify prior history of abuse or neglect as a key indicator for subsequent delinquency.[3] Other studies have found that maltreated children were significantly more likely to engage in behaviors considered high risk for delinquency, including teen pregnancy, drug use, lower grade-point averages, and assaultive behaviors, and had more reported mental health problems than nonmaltreated children in matched control groups.[4] Court-referred juvenile offenders were found to include a striking proportion of youth who had previously been victims of substantiated abuse or neglect (66 percent of male offenders and 39 percent of female offenders).[5] In a longitudinal study comparing maltreated children with a matched control group, the maltreated children were more likely to be arrested for juvenile offenses (27 percent compared to 17 percent for the control group) and were arrested more often (an average of 3 arrests compared to 2.4 for the control group).[6]

Preventing child abuse and neglect ultimately involves its own array of interventions. This article does not address primary or secondary prevention efforts, though these are of no less importance. It describes one demonstrably effective and attainable tertiary prevention strategy. "Tertiary prevention efforts" are those directed toward families who have already come to the attention of a child protective service agency and are designed to reduce the likelihood that children in those families will experience abuse or neglect in the future. Significant reduction in child abuse and neglect was achieved simply by improving the decision-making process in child protection agencies.

## DECISIONS IN CHILD MALTREATMENT CASES

Decision making in child maltreatment cases is a daunting task with potentially grave consequences. Each case is unique, often involving complex and confusing facts, and the stakes—the safety and welfare of a child—are very high. Errors can result in children remaining in unsafe circumstances or in needless allocation of scarce resources and unwarranted interventions. Added to these concerns, child protective service (CPS) workers—the first line of decision-makers—are often overworked, overwhelmed by the gravity of the choices they must make, and, too often, new to the job and inexperienced.

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According to a 1993–94 survey, nearly 3 million children were identified as the victims of maltreatment.[7] Not all abused or neglected children are reported to official agencies; even so, CPS agencies across the country daily receive thousands of phone calls reporting possible abuse and neglect. Approximately 40 percent of these official reports are screened out in the initial call and not assigned for investigation.[8] About one-third of the investigated reports of child maltreatment are confirmed. Over 800,000 abused or neglected children had officially substantiated CPS cases in 1999.[9]

The system fails when the agency does not respond adequately and the abuse or neglect continues. The problem of ensuring adequate CPS response is national in scope: more than 30 states have experienced class-action lawsuits concerning the delivery of child protective services. The decision-making environment facing CPS agencies is increasingly complex because of a confluence of factors:

- While actual referrals to CPS agencies have declined slightly over the past several years, this modest reduction follows more than a decade of robust increase. Few agencies have been able to keep pace with referrals, so that existing workforce strength lags far behind the amount of time needed to conduct adequate investigations and provide adequate services.
- Scarcity of workers, especially in certain communities, results in both continued exacerbation of staff shortages and employment of staff with nontraditional academic preparation and experience.
- Because of rapid staff turnover, workers with minimal experience often conduct investigations and provide services.

Child protection assessment and service delivery require a vast array of skills and knowledge. Clear analysis and good judgment are required in deciding which cases to investigate and which cases to focus the agency's greatest attention on. But in this environment, even the most expert child welfare workers tend to reach different decisions about the safety of children when presented with the same case information.[10] Many agencies are seeking improved decision-making models as a fundamental step toward improving outcomes.

One promising decision-making tool for CPS workers is the structured decision-making (SDM) system. This article describes the principles and elements of the SDM model developed by the Children's Research Center of the National Council on Crime and Delinquency.

## THE SDM MODEL

SDM is a strategy designed to reduce revictimization of children by improving the efficiency and effectiveness of CPS agencies. This improvement is accomplished by (1) increasing the consistency, objectivity, and validity of child welfare decisions and (2) focusing resources on families at the highest levels of risk for revictimization. SDM is currently in use in all or part of a number of states, including Alaska, California, Georgia, Michigan, Minnesota, New Hampshire, New Mexico, Ohio, Rhode Island, and Wisconsin.

### UNDERLYING PRINCIPLES OF THE SDM MODEL

The SDM model is based on four primary principles:

1. Decisions can be significantly improved when they are structured appropriately. Therefore, every worker in every case must consider a set of specific criteria using highly structured assessment procedures. Using common criteria across workers and across cases increases the consistency and accuracy of decisions.
2. Priorities assigned to cases and services delivered must correspond directly to the assessment process. Even the best assessments are of little use unless the actions taken are related to the results of the assessment. Yet in many systems currently, families are served with "one-size-fits-all" approaches: regulations often require the same level of contact with a family (i.e., one contact per month) regardless of the family's assessed risk level, and case plans often require parenting classes and counseling regardless of the family's identified strengths and needs. Instead, SDM ensures that the agency's highest priority is given to the most serious/highest-risk cases. SDM further increases the likelihood that agencies will address specifically identified service needs while reducing the often-automatic referrals to readily available, yet sometimes unnecessary, services.
3. Virtually everything that an agency does—from providing services in an individual case to allocating budgetary resources—should be a response to the assessment process. Data obtained from use of the SDM model provide a rich source of information on the range and extent of services needed in the community and shed light on the impact and effectiveness of agency policy and practice.
4. A single, rigidly defined model cannot meet the needs of every agency. Organizational structures, agency mandates, governing statutes, and regulatory environments

vary significantly from state to state. Rather than importing a decision system wholesale, each jurisdiction should tailor the system to its local needs and design a process that builds acceptance and local expertise into the model.

## PRINCIPAL COMPONENTS OF THE SDM MODEL

The SDM model consists of a set of assessment tools along with related definitions, policies, and procedures. Each tool is designed specifically for use at a particular key decision point in the life of a CPS case. By focusing on individual decision points for each tool, rather than considering all case information as a whole, the SDM model enhances clarity and allows agencies to more effectively monitor compliance with established policies and procedures.

Although SDM is a highly structured system, it is not rigid. No set of factors can account for all unique case and family characteristics, and no set of definitions can encompass the vast array of case features. Therefore, most SDM tools incorporate an override provision that allows a worker to change the assessment-indicated decision when necessary. In this way, SDM does not replace worker judgment but forms a dynamic partnership between structure and judgment.

### INITIAL INTAKE ASSESSMENT

At the time of referral, a worker must determine whether the report raises concerns that fall within the mandate of the CPS agency. Although statutes and regulations often define abuse and neglect, application of the definitions tends to be inconsistent. Reports of similar conduct to a CPS agency may result in an investigation at one time but not another. SDM's initial intake assessment tools include expanded and concrete examples to illustrate the kinds of situations the agency would investigate. The tools not only help screening workers improve consistency but also are useful for articulating agency policy to mandatory or voluntary reporters.

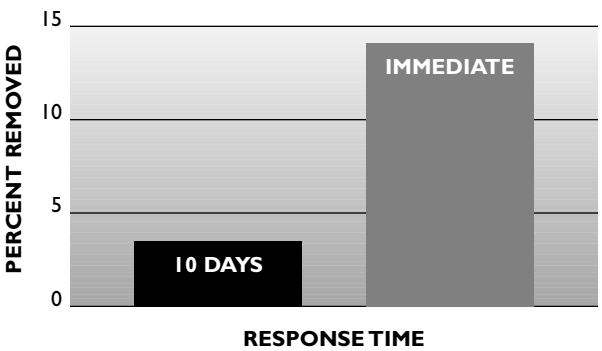
### RESPONSE PRIORITY ASSESSMENT

Once a worker has decided to assign a referral for investigation, he or she turns to a set of response priority tools that help determine how quickly to respond. Ideally, every call would receive an immediate response, but there are times when more calls come in than the available workers can process. A good triage process ensures that those calls deserving an urgent response will get one.

Response priority tools are typically built to address major categories of maltreatment (i.e., neglect, physical abuse, sexual abuse) and consist of decision trees that lay out a logical sequence of 3 to 10 critical questions. By answering these questions in order, a worker is guided to a response-time recommendation based on the characteristics of the report. Most jurisdictions sort referrals into two or three response times, such as immediate, 3-day, or 10-day. As with all SDM tools, the final step of the response priority assessment is to consider whether there are unique circumstances that warrant an override of the tool-derived decision.

Aggregate information from SDM jurisdictions suggests that the response priority instruments are effective. One way to examine effectiveness is by comparing the rates at which children are removed from their homes during the initial stage of the investigation. For investigations in which a nonimmediate response is recommended there should be very few instances in which conditions warrant removal of a child. Conditions severe enough to result in removal would warrant an immediate response so that the child is not left in dangerous conditions before the investigation begins. Thus, the rate of removal is expected to be far higher in immediate-response investigations, reflecting that the allocation of resources is appropriate—that is, a worker is immediately dispatched when conditions warrant. Application of the response priority assessment in over 20,000 referrals in California counties using SDM resulted in removals of children in 14 percent of all immediate-response cases, compared to only 3 percent in nonimmediate-response cases (Figure 1).[11]

**Figure 1. Removal rate by response time**




SOURCE: CHILDREN'S RESEARCH CTR., COMBINED CALIFORNIA COUNTIES: STRUCTURED DECISION MAKING CASE MANAGEMENT REPORT, JANUARY–DECEMBER 2000, at A1 (Children's Research Ctr., Nat'l Council on Crime & Delinquency (2001).

### SAFETY ASSESSMENT

The next key decision point occurs as the worker completes his or her first face-to-face contact with the child and family. Whether using a systematic assessment tool or individual clinical judgment, every worker in every case effectively makes a safety decision at the moment he or she takes custody of a child or leaves without the child. The safety assessment is a determination of the imminent threat of harm to the child if he or she remains in the home.

In SDM, the safety assessment consists of three parts. In the first section, the worker answers a set of 10 to 12 questions to establish whether conditions in the home pose substantial immediate danger to a child. The importance of the assessment is twofold. First, it ensures that critical areas are not overlooked. Second, it ensures that consistent safety standards are applied. This consistency contributes to equity in removal decisions. If workers observe no safety issues, children are not removed.

If one or more safety factors are present, the worker proceeds to the second section of the assessment, identification of possible in-home interventions. The tool lists actions, services, or agreements that can be put in place to ensure child safety while the investigation proceeds. This step documents the agency's reasonable efforts to prevent removal and, more important, facilitates a dialogue between the worker, the parent, and, in some cases, the extended family or community that clearly articulates the agency's safety concerns and helps to create a safety plan. In situations where no safety plan would adequately ensure child safety in the home, removal is the only option. The third step in the assessment is to record the final decision.

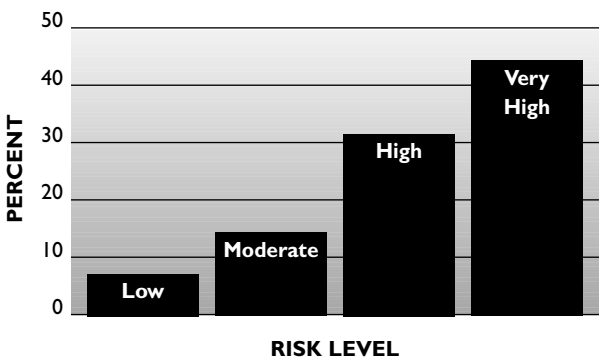
Although safety assessments may be characterized as simple checklists, their value cannot be overstated. Simplicity is, in fact, key to successful implementation, because CPS investigators are required to make safety decisions within very limited time frames. By allowing an investigator to focus on a relatively small set of important factors, safety assessments help investigators avoid mistakes and improve consistency.

### RISK ASSESSMENT

The heart of the SDM model is its actuarial risk-assessment tool. (See appendix for an example.) Unlike almost all other CPS risk-assessment approaches in use, SDM risk assessment is based on actuarial research. This methodology has produced tools that demonstrate more reliability and validity than consensus-based tools.[12] Higher reliability and validity translate into decision making that is equitable for families and that optimizes an agency's resources. When a highly reliable and valid risk assessment forms the backbone of a comprehensive decision-making system, an agency is well positioned to better protect children from revictimization.

In SDM, *risk* has a very specific definition: it is an estimate of the likelihood that a child who has come to the attention of a CPS agency will be victimized during the next 18 to 24 months. Recidivism rates for lower- and higher-risk families vary substantially. As shown in Figure 2, for example, in the California SDM model 93 percent of investigated low-risk families did not experience another substantiation within two years of the index investigation.[13] In contrast, among very high risk families nearly half of those investigated once had at least one more substantiation within two years.[14]

**Figure 2. Cases resubstantiated within two years, by risk level**




SOURCE: CHILDREN'S RESEARCH CTR., CALIFORNIA PRELIMINARY RISK ASSESSMENT 6 (Children's Research Ctr., Nat'l Council on Crime & Delinquency 1998).

#### *The Actuarial Method*

Prior to the appearance of actuarial risk assessments, consensus-based risk assessments were developed to bring some structure to the risk-assessment process. These consensus-based tools were typically developed by a group of child-protection experts, who used existing research, along with their experience, to determine what factors to include in the tools. The SDM approach differs in its construction. The SDM process begins similarly, with experienced workers proposing characteristics that could be observed during an investigation and that they believe will distinguish families who will experience recurrent abuse from those who will not. Often, workgroups generate lists of 150 to 200 items. Here the similarity ends. Instead of

using a consensus process to hone the list to a more manageable number of items, SDM uses actuarial research to measure all of the items in a large sample of actual cases. This measurement often consists of a retrospective review of case files for investigations that occurred 18 to 24 months prior to the study. For example, if the case file reflects that at the time of the investigation it was known that the primary caregiver had been diagnosed with alcohol dependency, and the study includes an item for alcohol dependency, it would be coded as such for the primary caregiver. Each of hundreds of files is similarly coded for each of hundreds of characteristics. Only information known at the time of the investigation can be used to code the items.

The second step is to open the remainder of each case file, so that workers can determine whether the family experienced subsequent negative events. Multiple events indicative of negative outcomes are measured. These can include re-referrals, resubstantiations, subsequent injuries, subsequent severe injuries, and subsequent out-of-home placements. Multiple outcome measures are needed because no absolute measure of recurrence exists. Much maltreatment goes undetected, and single measures such as referrals and substantiations can reflect quite varied practices. Checking the risk tool for validity on the basis of multiple outcomes helps reduce any potential bias that could result if a tool were to be built on a single measure.

Next, analysis of the relationship between case characteristics and outcomes is conducted to identify a set of characteristics that have the strongest correlation. These items are used to construct the risk assessment. Our research has consistently found that the most valid tools include separate indexes for estimating future neglect and future abuse. The tools are quite brief; each index typically includes around 10 items. Moreover, many items include concrete and easily observable and verifiable characteristics such as ages and number of children. This enhances both the reliability and accountability of the risk assessment. For example, items such as "low self-esteem" are more subjective. Even with clear definitions to guide whether to assess a parent as having low self-esteem or not, it is more difficult to have multiple workers reach the same conclusion. In contrast, it is likely that multiple workers would consistently agree on the number or ages of children. It is also easier for a supervisor to review case files and confirm that the worker accurately completed the risk assessment when items are concrete. To the extent that these concrete items are capable of accurately estimating risk, they are incorporated into the risk-assessment tool.

### *Decisions Based on Risk*

Because the risk tool accurately categorizes substantial differences in outcomes for families at various risk levels, knowing the risk level of a particular family helps target scarce agency resources. Low-risk families have a low rate of future substantiations, with or without agency intervention, so there is little benefit in allocating resources to them. In contrast, higher-risk families are substantially more likely to maltreat their children without agency intervention. More important, there is reason to believe that CPS intervention with higher-risk families is very effective. In several southeastern Wisconsin counties using SDM, low- and moderate-risk families had about a 14 percent re-referral rate regardless of whether the CPS agency provided postinvestigation services. In contrast, high- and very high risk families who were provided CPS services after the investigation had re-referral rates that were only about half as high as families in the same risk classification who did not receive services.[15]

These data support the SDM principle that risk level should guide the decision whether to open a case for ongoing services after the initial investigation. Higher-risk cases should be opened and provided with CPS services, while lower-risk cases may be effectively served by community agencies or may need no service at all.

Differential contact standards are a second application of risk level to decision making. In SDM, the higher the risk level of an open case, the more time a worker is expected to be in contact with the family. Differential contact standards set an expectation for worker contact and reflect the reality that certain cases consume far more worker time than others. Uniform standards that set the same expectation for worker time regardless of case characteristics simply do not reflect the need for variation. More important, without risk-based contact standards, worker time may accumulate among cases that are demanding but not necessarily high risk. In other words, workers can end up spending much time on activities that contribute little to the safety of children.

### *Limits of Risk Assessment*

Although actuarial risk-assessment tools are highly effective, they have certain limitations. First, they are not predictive. That is, results of the risk assessment should not be considered a prediction of future behavior but only as a classification: they place a family in a group of families that share certain characteristics and have a known outcome rate. No tool can predict with certainty whether a family will maltreat a child in the future. A large percentage of even the highest-risk families will not maltreat their children again, and a small percentage of the lowest-risk

families will do so. For this reason, risk level would be an inappropriate basis for the decision whether to remove a child from his or her parents. That decision is more effectively made by the safety assessment.

Second, the effectiveness of the method depends on the quality of the case files reviewed. It is possible that as knowledge of child abuse and neglect expands and case practice, including effective documentation, is strengthened, so too will actuarial tools capture increasingly robust items. There may be characteristics other than those typically appearing on current tools that are more highly correlated with outcomes but have been inconsistently documented in case files. Actuarial tools may miss these. Therefore, workers using tools have the right, and even the responsibility, to override a tool's risk estimate when they believe that a family presents unique considerations not captured by the tool. As mentioned above, this partnership between structure and judgment optimizes the value of the highly valid and reliable actuarial tools with the check-and-balance system of trusting the worker's knowledge and skill to identify exceptions.[16]

Finally, actuarial risk assessments are not designed to examine every aspect of a family that might be relevant to decisions about the most appropriate interventions for reducing the likelihood of future abuse or neglect. As a result, actuarial risk tools cannot form a basis for case planning. The family strength and need assessment is far better suited for this task.

## FAMILY STRENGTH AND NEED ASSESSMENTS

Families served by CPS agencies differ not only in their likelihood of experiencing recurrent problems, but also by their specific constellations of strengths and needs. Only by systematically assessing every family across a comprehensive set of domains does it become possible to identify the particular areas in which services are most needed.

SDM strength and need assessments typically consist of 10 to 12 critical domain areas, such as substance abuse/use, mental health, social support, and basic needs. The family is scored in each domain according to a scale ranging from "strength" to "severe need." (See Figure 3.) Each response within an item has a score based on how critical an issue is to reducing subsequent child abuse or neglect. Comparison of the scores on each item helps to identify the need areas to be addressed first. Case plans, then, typically focus on up to three main areas of need while incorporating identified strengths. When strength and need assessments are repeated over time, they help assess progress.

**Figure 3. Sample item from California Family Strength and Need Assessment**

**SN 1. Substance Abuse/Use**

(Substances: alcohol, illegal drugs, inhalants, prescription/ over-the-counter drugs)

| | |
|---|---|
| a. Teaches and demonstrates healthy understanding of alcohol and drugs | **+3** |
| b. Alcohol or prescribed drug use | **0** |
| c. Alcohol or drug abuse | **–3** |
| d. Chronic alcohol/drug abuse | **–5** |

## REASSESSMENTS

The risk assessment tools designed for the initial investigation typically do not work well at reassessment because they do not assess progress toward change. Reassessment tools better handle this function.

At regular intervals in the life of a case, reassessments help guide decisions about when to close the case, refocus case plans, and reset contact standards if the case remains open. Reassessments include some of the most significant risk factors considered in the initial risk tool and evaluate progress toward the case plan's goal. Using this tool helps reduce the potential for cases to remain open—continuing to consume agency resources—despite diminishing returns from the investment of CPS services.

Reassessments are particularly vital for children in out-of-home care. Based on local agency statutes and regulations, reunification must occur within specific time limits. Children returning to their parents must have lower risk levels at reassessment, and their parents must have demonstrated acceptable visitation. The final step toward reunification is an assessment of safety concerns. If any of these three conditions—risk level, visitation, or safety—falls below the acceptable level, the child will not be returned home. The decision model also incorporates the required time limits. Based on the time already in care and the age of the child, a decision tree guides the worker toward a recommendation either to continue to provide reunification services or to change the permanency-plan goal.

## IMPLEMENTATION ISSUES

A decision model such as SDM requires several critical changes in work culture:

- A change from clinical judgment alone to a partnership between research, structure, and judgment

  There is often initial resistance to SDM by a small segment of workers who prefer to continue to make decisions based on their own knowledge, experience, and values. Alternatively, some workers are prone to rely too mechanically on tools without exercising their responsibility to override results where appropriate. Skilled supervisors can help staff achieve the optimal balance between research, structure, and judgment.

- Refocusing resources toward higher-risk families, regardless of whether an investigation is substantiated or not

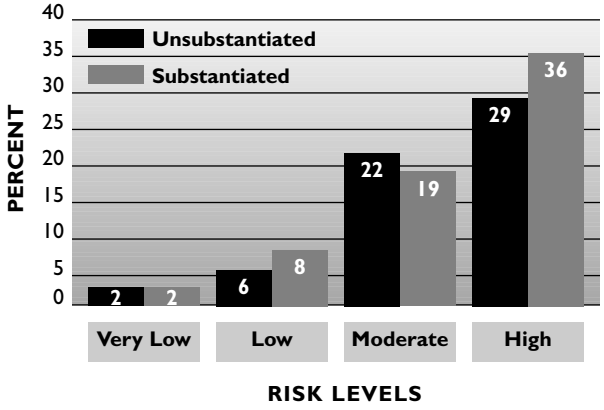
  Practice in many jurisdictions has evolved in ways that make substantiated cases far more likely to be opened than unsubstantiated cases regardless of risk level. On the one hand, there is a reluctance to close lower-risk cases that are substantiated, even though an overwhelming percentage of low-risk families will not maltreat again. On the other hand, unsubstantiated or inconclusive higher-risk cases are rarely opened. Without evidence to support a court order, it is often suggested, there is little a CPS agency can do.

  Children's Research Center research in New Mexico provides strong evidence that recurrence has little to do with current substantiation status. New maltreatment was about as likely in unsubstantiated cases as in substantiated ones when controlling for risk level. It is true for inconclusive or unsubstantiated cases, however, that families must be allowed to voluntarily accept or reject services. The SDM impetus to open all higher-risk cases, regardless of substantiation status, requires a commitment to work toward engaging a family in services based on a mutual concern for the child's safety and well-being. While this effort to engage families will sometimes fail, the New Mexico findings strongly suggest that when we fail to engage higher-risk families in treatment-oriented services today, those same families will probably consume investigation resources tomorrow. More critical, a child may be harmed while the system waits for evidence to substantiate. (See Figure 4.)

- Using data to inform decisions throughout the agency

  While SDM has tremendous value for guiding decisions in individual cases, its value is enhanced when an agency uses aggregate data to make policy, program, and financial decisions. For example, the family strength and need assessment provides a thorough picture of the needs profiles of all families served by the agency. This information can serve as a basis for dialogue with community organizations about matching available services to actual needs.

**Figure 4. Unsubstantiated and substantiated cases, by risk level**




SOURCE: D. Wagner & B. Meyer, Using Actuarial Risk Assessment to Identify Unsubstantiated Cases for Preventative Intervention in New Mexico 14 (1998) (paper presented at 12th National Roundtable on CPS Risk Assessment).

## EVALUATION OF SDM MODELS

Rarely has any new child welfare program or concept been as thoroughly examined as SDM. This examination is ongoing and is useful in both confirming that the model is working and pointing out areas requiring improvement. In addition to regularly gathered management data, several controlled research designs have examined the impact of SDM models. This section reports key findings from those studies.

Michigan began using SDM in 13 counties in 1992. An evaluation of SDM's effectiveness was conducted three years later.[17] Approximately 900 families investigated by the 13 SDM counties were compared to a similar number of families investigated by a matched set of 13 comparison counties. All families were followed for 12 months after the index investigation.

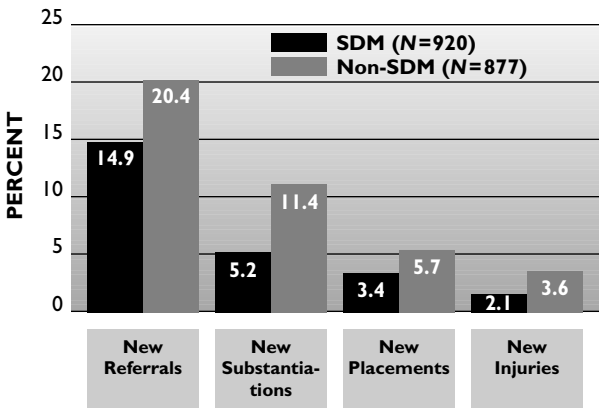
The study found that SDM jurisdictions apparently made more effective decisions about which families to serve postinvestigation. Even though SDM counties

closed a higher percentage of cases immediately upon concluding the investigation, closed cases in SDM counties had fewer subsequent referrals, substantiations, injuries, and placements than did closed cases in non-SDM counties. SDM counties were also more effective at getting targeted services to families with specific identified needs. For example, among all families identified as needing family counseling in SDM counties, about 40 percent actually received family counseling. While this percentage is far below optimal, only 25 percent of families with an identified need for family counseling received it in non-SDM counties.

Finally, in terms of ultimate outcomes, families in SDM counties experienced significantly fewer new referrals, new substantiations, subsequent injuries, and foster placements compared to families in non-SDM counties. Figure 5 shows that for every outcome measured using official statistics, counties using SDM lowered the rates of child maltreatment.

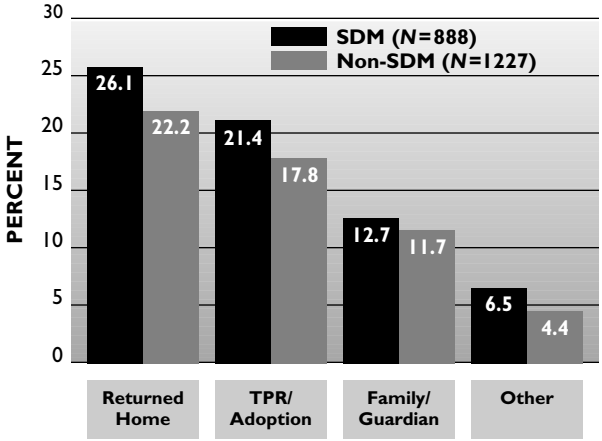
The reunification assessment was evaluated in another study of SDM in Michigan.[18] Figure 6 shows that significantly more children were moved to permanency in SDM counties (67 percent) than in non-SDM counties (56 percent). Even more striking, increased permanency was achieved in all permanency-status categories.

**Figure 5. Cases with new child maltreatment outcomes in a 12-month follow-up in SDM and non-SDM counties**




SOURCE: S. C. BAIRD ET AL., MICHIGAN DEPARTMENT OF SOCIAL SERVICES STRUCTURED DECISION MAKING SYSTEM: AN EVALUATION OF ITS IMPACT ON CHILD PROTECTIVE SERVICES 17 (Children's Research Ctr., Nat'l Council on Crime & Delinquency 1995).

**Figure 6. Cases achieving permanency within 15 months of entering foster care in SDM and non-SDM counties**




SOURCE: D. WAGNER ET AL., EVALUATION OF MICHIGAN'S FOSTER CARE STRUCTURED DECISION MAKING CASE MANAGEMENT SYSTEM 21 (Children's Research Ctr., Nat'l Council on Crime & Delinquency 2001).

## CONCLUSION

SDM is not a panacea for the vast and complex issues facing CPS agencies. While SDM is an excellent teaching tool, it is not a substitute for comprehensive conceptual and theoretical education for workers. SDM may help newly hired workers learn critical decision-making skills more quickly, but it should not replace efforts to reduce rapid turnover in the first place.

Moreover, while SDM can help in the allocation of existing CPS resources in ways that bring about the greatest reductions in subsequent victimization, existing resources may be insufficient to achieve optimal results. SDM can effectively categorize families on the basis of risk and identify critical needs to be addressed, but if services to meet those needs do not exist in the community, categorization alone will simply not be enough.

Implementing SDM is far from a "turnkey" operation. It is not enough for an agency to hand out a new set of assessment forms. SDM's full value depends on careful preimplementation planning, comprehensive training, and continued attention to the quality of implementation. It takes no small effort to make the paradigm shifts discussed in this article, especially when many CPS jurisdictions have a full plate of regulatory changes, automation issues, and a plethora of new policies, programs, and initiatives competing for attention.

It is encouraging, however, that even faced with the enormity of its task, a CPS agency can implement SDM with sufficient quality to achieve a measurable reduction in child victimization. The Michigan evaluation studies cited in this article suggest that, all else being equal, jurisdictions implementing SDM can achieve improved outcomes. SDM represents one practical and efficient way to improve the nation's CPS systems and, in turn, help reduce harm to children.

## NOTES

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4. Barbara T. Kelley et al., *In the Wake of Childhood Maltreatment,* JUV. JUST. BULL. 1 (Office of Juvenile Justice & Delinquency Prevention, Aug. 1997).

5. JOHN PAWASARAT, IDENTIFYING MILWAUKEE YOUTH IN CRITICAL NEED OF INTERVENTION: LESSONS FROM THE PAST, MEASURES FOR THE FUTURE 1 (Univ. of Wisconsin Employment & Training Inst. 1991).

6. Cathy S. Widom, *The Cycle of Violence,* RESEARCH IN BRIEF 1 (U.S. Dep't of Justice, Oct. 1992); Cathy S. Widom, *Victims of Childhood Sexual Abuse—Later Criminal Consequences,* RESEARCH IN BRIEF 1 (U.S. Dep't of Justice, Mar. 1995); Michael G. Maxfield & Cathy S. Widom, Childhood Victimization and Patterns of Offending Through the Life Cycle: Early Onset and Continuation (1995) (paper presented at the annual meeting of the American Society of Criminology).

7. ADMIN. ON CHILDREN, YOUTH & FAMILIES, U.S. DEP'T OF HEALTH & HUMAN SERVS., THE THIRD NATIONAL INCIDENCE STUDY ON CHILD ABUSE AND NEGLECT (1996), www.calib.com/nccanch/pubs/statinfo/nis3.cfm.

8. ADMIN. ON CHILDREN, YOUTH & FAMILIES, U.S. DEP'T OF HEALTH & HUMAN SERVS., CHILD MALTREATMENT 1997: REPORTS FROM THE STATES TO THE NATIONAL CHILD ABUSE AND NEGLECT DATA SYSTEM (1999), www.calib.com/nccanch/pubs/factsheets/canstats.cfm.

9. *Id.*

10. PETER H. ROSSI ET AL., UNDERSTANDING CHILD MALTREATMENT DECISIONS AND THOSE WHO MAKE THEM (Chapin Hall Ctr. for Children, Univ. of Chicago 1996).

11. CHILDREN'S RESEARCH CTR., COMBINED CALIFORNIA COUNTIES: STRUCTURED DECISION MAKING CASE MANAGEMENT REPORT, JANUARY–DECEMBER 2000, at A1 (Children's Research Ctr., Nat'l Council on Crime & Delinquency 2001).

12. S. Christopher Baird et al., *Risk Assessment in Child Protective Services: Consensus and Actuarial Model Reliability,* 78 CHILD WELFARE 723 (1999); S. Christopher Baird & Dennis Wagner, *The Relative Validity of Actuarial and Consensus-Based Risk Assessment Systems,* 22 CHILD. & YOUTH SERVICES REV. 839 (2000); *see* GEORGE FALCO, CLINICAL VS. ACTUARIAL RISK ASSESSMENT: RESULTS FROM NEW YORK STATE (Office of Program Evaluation, N.Y. Dep't of Soc. Servs., in press).

13. The index investigation is the first investigation that occurred during the study period. For some families, this is the first-ever investigation, while others had prior CPS investigations as well.

14. CHILDREN'S RESEARCH CTR., CALIFORNIA PRELIMINARY RISK ASSESSMENT 5 (Children's Research Ctr., Nat'l Council on Crime & Delinquency 1998).

15. High risk: closed after investigation = 28% re-referral rate vs. open for service = 15% re-referral rate. Very high risk: closed after investigation = 45% re-referral rate vs. open for service = 24% re-referral rate. *See* DENNIS WAGNER & PAT BELL, THE USE OF RISK ASSESSMENT TO EVALUATE THE IMPACT OF INTENSIVE PROTECTIVE SERVICE INTERVENTION IN A PRACTICE SETTING (Children's Research Ctr., Nat'l Council on Crime & Delinquency 1998).

16. In practice, SDM override rates generally range from 2 to 8 percent. Lower rates may suggest that tools were being used too mechanically, without attention to unique

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circumstances. Rates above 10 percent raise serious doubt about the tool's validity and utility or the effectiveness of training in the appropriate use of the tool.

17. S. CHRISTOPHER BAIRD ET AL., MICHIGAN DEPARTMENT OF SOCIAL SERVICES STRUCTURED DECISION MAKING SYSTEM: AN EVALUATION OF ITS IMPACT ON CHILD PROTECTIVE SERVICES (Children's Research Ctr., Nat'l Council on Crime & Delinquency 1995).

18. DENNIS WAGNER ET AL., EVALUATION OF MICHIGAN'S FOSTER CARE STRUCTURED DECISION MAKING CASE MANAGEMENT SYSTEM (Children's Research Ctr., Nat'l Council on Crime & Delinquency 2001).

APPENDIX

## CALIFORNIA FAMILY RISK ASSESSMENT OF ABUSE/NEGLECT

**Family Case Name:** _____ **Family Case #:** _____

**County Name:** _____ **County #:** _____ **Office:** _____

**Worker Name:** _____ **Worker #:** _____ **CPS Referral Date:** ___/___/___ **Assessment Date:** ___/___/___

### Neglect

N1. Current investigation is for neglect
- a. No....0
- b. Yes....1 ____

N2. Number of prior abuse/neglect investigations
- a. None....0
- b. One....1
- c. Two or more....2 ____

N3. Number of children in the home
- a. Two or fewer....0
- b. Three or more....1 ____

N4. Number of adults in home at time of investigation
- a. Two or more....0
- b. One/none....1 ____

N5. Age of primary caregiver
- a. 30 or older....0
- b. 29 or younger....1 ____

N6. Characteristics of primary caregiver (check & add for score)
- a. Not applicable....0
- b. Parenting skills are a major problem....1
- c. Lacks self-esteem....1
- d. Apathetic or feeling of hopelessness....1 ____

N7. Primary caregiver involved in harmful relationships
- a. No....0
- b. Yes, but not a victim of domestic violence....1
- c. Yes, as a victim of domestic violence....2 ____

N8. Primary caregiver has a current substance abuse problem
- a. No....0
- b. Alcohol *only*....1
- c. Other drug(s) (with or without alcohol)....3 ____

N9. Household is experiencing severe financial difficulty
- a. No....0
- b. Yes....1 ____

N10. Primary caregiver's motivation to improve parenting skills
- a. Motivated and realistic....0
- b. Unmotivated....1
- c. Motivated but unrealistic....2 ____

N11. Caregiver(s) response to investigation and seriousness of complaint
- a. Attitude consistent with seriousness of allegation and complied satisfactorily....0
- b. Attitude not consistent with seriousness of allegation (minimizes)....1
- c. Failed to comply satisfactorily....2
- d. Both b and c....3 ____

**TOTAL NEGLECT RISK SCORE** .... ____

### Abuse

A1. Current investigation is for physical, sexual or emotional abuse
- a. No....0
- b. Yes....1 ____

A2. Prior abuse investigations
- a. None....0
- b. Physical/emotional abuse....1
- c. Sexual abuse....2
- d. Both b and c....3 ____

A3. Prior CPS service history
- a. No....0
- b. Yes....1 ____

A4. Number of children in the home
- a. One....0
- b. Two or more....1 ____

A5. Caregiver(s) abused as child(ren)
- a. No....0
- b. Yes....1 ____

A6. Secondary caregiver has a current substance abuse problem
- a. No, or no secondary caregiver....0
- b. Yes (check all that apply)
  - ____ Alcohol abuse problem
  - ____ Drug abuse problem....1 ____

A7. Primary or secondary caregiver employs excessive and/or inappropriate discipline
- a. No....0
- b. Yes....2 ____

A8. Caregiver(s) has a history of domestic violence
- a. No....0
- b. Yes....1 ____

A9. Caregiver(s) is an over-controlling parent
- a. No....0
- b. Yes....1 ____

A10. Child in the home has special needs or history of delinquency
- a. No....0
- b. Yes *(check all that apply)*
  - ____ Diagnosed special needs
  - ____ History of delinquency....1 ____

A11. Secondary caregiver motivated to improve parenting skills
- a. Yes, or no secondary caregiver in home....0
- b. No....2 ____

A12. Primary caregiver's attitude is consistent with the seriousness of the allegation
- a. Yes....0
- b. No....1 ____

**TOTAL ABUSE RISK SCORE**.... ____

### INITIAL RISK LEVEL

Assign the family's risk level based on the highest score on either scale, using the following chart:

| Neglect Scale | Abuse Scale | Risk Level |
|---|---|---|
| ____ 0–4 | ____ 0–2 | ____ Low |
| ____ 5–7 | ____ 3–5 | ____ Moderate |
| ____ 8–12 | ____ 6–9 | ____ High |
| ____ 13–20 | ____ 10–16 | ____ Very High |

**FINAL RISK LEVEL: ___ Low ___ Moderate ___ High ___ Very High**

### OVERRIDES

Policy: Override to Very High. Check appropriate reason.
- ___ 1. Sexual abuse cases where the perpetrator is likely to have access to the child victim.
- ___ 2. Cases with nonaccidental physical injury to an infant.
- ___ 3. Serious nonaccidental physical injury requiring hospital or medical treatment.
- ___ 4. Death (previous or current) of a sibling as a result of abuse or neglect.
- ___ 5. Positive tox screen (any drug, including alcohol) of mother or child.

Discretionary: Override to increase one risk level
- ___ 6. Reason: _____

_____ ___/___/___

Supervisor Review/Approval Date